Appendix 13

Prior Authorization Request Form (PA/RF) Completion Instructions

The Prior Authorization Request Form (PA/RF) functions as a cover sheet and asks for general information regarding the provider, the recipient, and the service(s) for which PA is being requested. Carefully complete the PA/RF and appropriate attachments, and submit to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers also have the option of submitting PA requests by fax at (608) 221-8616. Refer to Appendix 22 of this section for more information about faxing PA requests. Providers may get their questions answered about completing PA requests by calling Provider Services at (800) 947-9627 or (608) 221-9883. Order copies of the PA/RF by writing to Wisconsin Medicaid. Include a return address, the name of the form, and the number of copies needed. Mail the request to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Element 1 — Processing Type

Enter the three-digit processing type "117" (physician services, including family planning clinic and rural health clinic). The "processing type" is a three-digit code used to identify a category of service requested. *Use 999 — "Other" only if the requested category of service is not considered within the category of physician services.*

Element 2 — Recipient's Medical Assistance ID Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 3 — Recipient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 4 — Recipient Address

Enter the complete address (street, city, state, and ZIP code) of the recipient's place of residence. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 — Date of Birth

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955).

Element 6 — Sex

Enter an "X" to specify male or female.

Element 7 — Billing Provider Name, Address, ZIP Code

Enter the billing provider's name and complete address (street, city, state, and ZIP code). *No other information should be entered into this element since it also serves as a return mailing label.*

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Element 8 — Billing Provider Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 — Billing Provider No.
Enter the billing provider's eight-digit Medicaid provider number.

Element 10 — Dx: Primary
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

Element 11 — Dx: Secondary
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

Element 12 — Start Date of SOI (not required)

Element 13 — First Date Rx (not required)

Element 14 — Procedure Code
Enter the appropriate *Current Procedural Terminology*, Health Care Procedure Coding System, formerly HCFA Common Procedure Coding System, or local procedure code for each service/procedure/item requested.

Element 15 — MOD
Enter the two-digit modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medicaid policy and the coding structure used) for each service/procedure/item requested. When requesting PA for a bilateral procedure, indicate the "50" modifier in this element.

Element 16 — POS
Enter the appropriate Medicaid single-digit place of service (POS) code designating where the requested service/procedure/item would be provided/performed. Refer to Appendix 2 of this section for a list of POS codes and their descriptions.

Element 17 — TOS
Enter the appropriate Medicaid single-digit type of service (TOS) code for each service/procedure requested. Refer to Appendix 1 of this section for a list of Medicaid procedure codes and their allowable TOS codes. Refer to Appendix 2 of this section for a list of TOS codes and their descriptions.

Element 18 — Description of Service
Enter a written description corresponding to the appropriate three-digit revenue code, five-digit procedure code, or 11-digit National Drug Code for each service/procedure/item requested.

Element 19 — QR
Enter the quantity (e.g., number of services, dollar amount) for each service/procedure/item requested.

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Element 20 — Charges

Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

Note: The charges indicated on the PA/RF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Family Services *Terms of Provider Reimbursement.*

Element 21 — Total Charge

Enter the anticipated total charge for this request.

Element 22 — Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid methodology and policy. If the recipient is enrolled in a managed care program at the time a prior authorized service is provided, Wisconsin Medicaid reimbursement is only allowed if the service is not covered by the managed care program.

Element 23 — Date

Enter the month, day, and year (in MM/DD/YYYY format) the PA/RF was completed and signed.

Element 24 — Requesting Provider Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

Do not enter any information below the signature of the requesting provider. This space is reserved for Wisconsin Medicaid consultants and analysts.